



EQUALITY • LAW • JUSTICE

Memo

To: Lt. Governor Jeff Coyer

From: Disability Rights Center of Kansas

CC:

Date: 2/28/2011

Re: Medicaid Cost Efficiencies – Request for stakeholder feedback.

1. Rising use of Institutional care has a two-fold effect on costs.

Costs of maintaining an individual in an Institutional setting increases not only the daily costs per individual, but it also costs the state more in terms of diminished long term health outcomes and lack of functional gains. Individuals who are Institutionalized for long periods are less likely to be able to be served in a less-restrictive, less-costly settings.

Lack of Coordination - Coordination issues exist for many individuals in facilities. NFMH Screens for Continued Stay, PRTF Screens and CBSTs (Certifications of Need), and hospital screens reflect a practice of tailoring an assessment based upon the assessor's limited understanding of what community resources are available (or not available), rather than specifically what supports and services a resident needs in order to be adequately supported in the community. This results in an often unnecessary increase in Length of Stay (LOS) in institutions and hospitals. The Money Follows the Person (MFP) program is developing a new process to ensure regular assessment and exploration of opportunities for living in the community, though it is not yet functional. This process will be provided to individuals in NFs, Rehab hospitals, and ICF-MRs.

Screen Problems Increase Inpatient Stays, Reducing Community Integration and Costing Taxpayers - In the case of screening and assessment for mental health facilities like NFMHs, the KVC STAR programs, and PRTFs, there is an enormous problem of the assessments simply not being complete and therefore no real assessment of community supports is done. In many cases the screener or team doing the assessment does not complete the screen/certification of need despite clear directions on the forms to do so. Instead, screeners, simply write in that the recommendation is for continuing the stay without any supporting documentation of why the continued stay will benefit the individual and what barriers exist to services in the community. The result is an overall failure of the assessment process and no real **informed consent or informed objection** by the families/guardians. In the case of children with mental

health needs, this issue has been reviewed and commented on by the Governor's Children's Mental Health Subcommittee. (see attached)

Fix Access Issues for MFP - For individuals who are eligible for the Money Follows the Person (MFP) program, the assessment and Community Bridge Building (CBB) process appears to have been largely ineffective for the life to date of the Demonstration Grant. The CBB process was developed to help individuals who choose services on the MFP program over institutions to actually transition to the community. The concept behind the CBB Teams was that a collaboration of institutional and community based service providers would meet regularly to problem solve and remove barriers. The information we were given said that of the 900 or so individuals who informed the Ombudsman's office that they desired community based placement, only 1 was transitioned successfully with the CBB process. Individuals eligible for MFP are people who have a Physical Disability, a Developmental Disability, a Traumatic Brain Injury, or seniors who are eligible for the Frail Elder Waiver. They must have had a stay in the facility for at least 90 days to qualify. Recent efforts have been planned but not yet implemented to improve transition services for the MFP program. The state has applied for a grant to set up a different system with MFP, that if funded by the federal government, has the opportunity to improve these efforts.

2. Under-utilized home and community based services creates cost shift to more expensive services like Institutions, foster care, and juvenile justice.

The following services are largely underutilized and, if available when needed, would decrease costs by diverting from more costly levels of services and would improve health outcomes for individuals with chronic care needs.

Services not provided (or where the service is systemically thwarted or marginalized)

- #1 - Positive Behavior Support (State Plan – Intensive Behavioral Service)
- #2 - Peer Support Specialists (State Plan – Mental Health Rehabilitation Service)
- #3 - Night Support/Sleep Cycle Support – (PD & FE Waiver Service)
- #6 - EPSDT – Early Periodic Screening, Diagnosis, and Treatment
- #7 - Assistive and Augmentative Speech Devices
- #8 - Professional Family Resource Homes (SED Waiver & PRTF Alt Waiver service)
- #9 - Residential Services for Children with MR/DD (MR/DD Waiver service)
- #10 - Crisis Intervention (Mental Health State Plan service)

Individuals not covered

People who reside in NFMHs could be more efficiently served in the community under a Recovery Model with expansion of Peer Support Specialist program. Adults in NFMHs – very often clearly eligible for both the PD waiver and Rehab services from a CMHC, yet often neither sets of supports are identified on Screens for Continued Stay. Lack of access to Peer Support Services for Transition Age Youth with Serious Emotional Disturbance (SED) and adults with Severe and Persistent Mental Illness (SPMI) increases institutional costs.

Research supporting the cost-effectiveness of Peer Support Specialist (PSS) services has been mounting for decades. One reason for the lack of access to Peer Support Specialist (PSS) services, and consequently lack of evidence for its cost-effectiveness in Kansas, is that individual mental health centers have been allowed by KHS and the state to set arbitrary limits on the amount and scope of PSS services to consumers. Example – Individual CMHCs have declared that PSS services would not be made available to individuals in their homes and communities, instead, only in group settings. Research clearly shows this model of PSS does not produce cost-efficiency under Medicaid.

Improve services and supports to Transition Age Youth – Services to Transition Age Youth could be improved in other states by using youth-to-youth outreach and advocacy programs and connection to underutilized supports in the community. Described as a child with a disability who is 14 to 21 years of age, these youth are chronically underserved. They populate the Youth Residential Centers (YRCs) which are

group homes, PRTFs, and Emergency Shelters largely due to inadequate housing in the community and lack of foster care placements. Many of these youth are not informed of and are not able to access Independent Living Counseling services on their own. Therapeutic or employment services are often not made available or are not tailored for their needs or are not age appropriate. Studies show that improved access to services for this population has an exponential affect on health and life outcomes. Costs savings would be derived from less dependence on Institutions and Emergency Shelters and improved employment opportunities.

3. Denial of Behavioral Health Services to Dually Diagnosed Individuals (MR/DD and Mental Illness) creates an unfair and costly system of supports for Kansans with DD.

Dually Diagnosed children and adults – MR/DD and MI. For a population that should be eligible for the gamut of services that cross several service systems, these individuals are often left with the least access due to lack of sufficient quality, quantity, and geographic diversity of services. The primary support service Dually Diagnosed individuals receive to help them live an inclusive life in the community is Supportive Home Care (SHC). SHC is a very basic Medicaid service with a low reimbursement rate. It falls under the category of personal care services, which is the service category with the very highest rate of turnover. SHC staff are typically have minimum standards for education/experience, not well supervised, and are not trained well enough to be able to work confidently or competently with anyone who requires specialized supports in order to live in the least restrictive environment.

Improve access to cost saving Behavioral Health services by addressing denials that rely on 'Clinical Judgment' - When Mental Health services are not carefully evaluated on assessments either during an individual's stay in a facility or prior to a stay for those in the community who are at risk for institutionalization, the individual is left to rely on the compliance of their local community based services provider to state and federal standards. When 'clinical judgment' can be used as a reason to deny an otherwise needed service, access to services and supports varies greatly from community to community. The state often allows service providers to rely more on their own 'clinical judgment' with regard to eligibility and access - versus using the standardized Functional Assessments required by Medicaid. Due to the problem of the state's reliance on 'clinical judgment', the geographic variability of available services can be arguably described as 'Cherry Picking'.

SRS supports a decision by a mental health center to deny Behavioral Health services to an adolescent age youth with Autism. Despite Medicaid rules against discrimination because of type of diagnosis, Behavioral Health services are widely denied based on intellectual deficits. SRS has opined that an adolescent with Autism "... *does not meet the functional criterion due to his[sic] severe intellectual deficits.*" By validating that a Mental Health Center can make a determination to rule out a person simply because of IQ testing, a gap in services for people with Developmental Disabilities was created. Kansans with DD are less likely to receive community Behavioral Health services and are forced to either accept a limited type and amount of services in the community, or face long-term institutionalization in either Parsons ICF-MR or the Kansas Neurological Institute ICF-MR. For example, SRS also validated decisions by Mental Health Centers to ignore behavioral health diagnoses (Dx) from multiple clinicians who do not work at the Mental Health Center. SRS's argument is that a Mental Health Center may also deny services by changing Dx's at the time of the mental health center's own assessment.

In order to fix the problem of discrimination against individuals with Development Disabilities (DD), prevent unnecessary Institutionalization of people with DD, and ensure Informed Choice for those who are Institutionalized, the DRC supports the development of and ready access to Crisis Stabilization services specific to persons with DD. The state must develop Mobile Crisis Teams and Crisis Respite Homes. Crisis Intervention must be available to the person with DD anywhere they live, work, attend school, or socialize. The goal of Crisis Intervention, Mobile Crisis Teams, and Crisis Respite Homes must be to divert from a more restrictive level of care.

Problems with Cross System Coordination of Services - Other efforts to ensure cross system coordination of services have often been ineffective. Care Coordination from the behavioral health contractor, Kansas Health Solutions (KHS), has been known to have been at odds with recommendations from treating physicians and requests from families for services. The KHS Care Coordinators do not plan services or assist with access. They emphatically inform families that only the network providers whom they contract with (CMHCs) can assess and coordinate services. This means that families are not informed of the availability of services, let alone ensured access, until they arrive at the door of their local provider for an intake. We have heard from families that this creates an overwhelming feeling of insecurity with families/guardians and, in their opinion, forces them to accept what they are given, versus being able to choose services, choose service providers, or actively participate in service planning.

Failure to Provide Informed Consent Costs Taxpayers over \$115,000 per person at KNI & Parsons - There does not appear to be true informed consent for the guardians and families of persons who are housed at Parsons State Hospital or KNI. If true, this would be in violation of the position of the Department of Justice (DOJ) and amount to an Olmstead Violation. Instead of being given accurate, data-driven information about the effectiveness and superiority of community-based alternative to expensive ICFs/MR, guardians were recently given a booklet that is nothing more than a laundry list of questions that they are to ask prospective service providers (see attached "Learning About Community Services"). Not only does this booklet not teach the reader NOTHING about community services, it actually has the net effect of scaring families about making a move and perpetuates the status quo. No reasonable person would read this booklet and reach the conclusion that community based services were a great option. At the end of reading through the laundry list of question after question, a confused guardian or family member would likely reach the conclusion that moving to the community is a very difficult process fraught with perils and pitfalls. This is a gross misperception of community based services. The questions raised in this "tool", by their sheer volume, scope, and veracity, serve no other legitimate purpose than to have a chilling effect and prevent moving people to more inclusive, less expensive, and better community based alternatives. This document was obviously written by institutional staff and family members who have a conflict of interest, and merely want to see the institution be perpetuated. The DOJ's position is that you have to provide meaningful, reasoned and informed consent (or informed objection) to an issue like moving to a community based setting. The "learning about community services" workbook fails to meet this DOJ standard. In fact, it does the opposite. In short, it provides "misinformed" objection to community based placements. This bias ends up costing tax payers over \$115,000 for every person who stays at KNI/Parsons and doesn't move to the community after they have been scared by this "tool for guardians." There are 350 Kansans at KNI and Parsons, and we are spending over \$40 million more on this level of care than on the less restrictive level of care for community services.